# THE NEED TO KNOW

ADMINISTRATIVE REVIEW OF **WOODLANDS SCHOOL**

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**WOODLANDS SCHOOL** REPORT:
AN ADMINISTRATIVE REVIEW

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SUBMITTED TO THE
MINISTRY OF CHILDREN
AND
FAMILY DEVELOPMENT

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*A sense of responsibility towards all others also means*
*that both as individuals and as a society of individuals,*
*we have a duty to care for each member of our society.*
*This is true irrespective of their physical capacity or of their*
*capacity for mental reflection. Just like ourselves, such people have*
*a right to happiness and to avoid suffering. We must therefore avoid,*
*at all cost, the urge to shut away those who are grievously afflicted*
*as if they were a burden. The same goes for those who are diseased or*
*marginalized. To push them away would be to heap suffering on suffering.*
*If we ourselves were in the same condition, we would look to others for help.*
*We need, therefore, to ensure that the sick and afflicted person never*
*feels helpless, rejected or unprotected. Indeed, the affection*
*we show to such people is, in my opinion, the measure of*
*our spiritual health, both at the level of the*
*individual and at that of society.*

*His Holiness the Dalai Lama,*
*Ancient Wisdom, Modern World: Ethics for the New Millennium, at p. 176*

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# INTRODUCTION

The Ministry of Children and Family Development, previously the Ministry for Children and Families ["the Ministry"], initiated this review as a result of a number of isolated complaints which had been filed with the police and became public through the media. The complaints apparently involved allegations of physical abuse at Woodlands School ["Woodlands"]. Government responded with a decision to conduct this review. At the same time, though unbeknownst to the public, there was at least one civil proceeding involving Woodlands in progress. Although there was no press release at the time the review was begun in the spring 2000, some of the community leaders in the disability movement were put on notice by the Ministry. Late this spring, the Vancouver SUN ran an article about allegations of abuse at Woodlands that made the fact that the review was in progress widely known.

This very deliberate step by government represents a departure from comparable situations in the past because of the terms of reference for the proposed review. It was intended to scrutinize the administrative records of Woodlands with a view to discovering if there was any evidence of systemic abuse at the institution. It was government's intention at the outset that if the administrative review showed evidence of systemic abuse, a second phase would follow in which people would have the opportunity to be heard. Because the review can be characterized as proactive, it is seen as an act of notable civility reflecting genuine respect for the prior residents of Woodlands.

The scope of the review was defined in the following context:

*Whereas:*

*A. The Province operated the Woodlands Institution for persons with mental disorders who required care, supervision and control for their own protection or welfare or the protection of others;*

*B. Woodlands operated from 1878 to 1996 and admissions to the institution were made under the statutory authority of the Province's mental health legislation, child welfare legislation or as voluntary committals;*

*C. In February 2000 allegations of physical abuse at Woodlands were subject of public broadcast during which the New Westminster City Police indicated that it had received complaints from three former residents which it had investigated but no charges had been laid; and*

*D. The Ministry for Children and Families wishes to determine whether there is information on files which might assist all parties in addressing general concerns raised with respect to past policies and practice at Woodlands.*

*E. The scope of this review includes physical and sexual abuse of residents at Woodlands. For purposes of this review definitions are as follows:*

*Physical Abuse*

- *Any excessive or inappropriate physical force directed at an individual by a person in a position of trust or authority.*

*Sexual Abuse*

- *Any sexual behaviour directed at an individual by a staff member, volunteer or any other person in a position of trust or authority.*

*Definitions may be modified as determined by the Ministry during the period of this review.*

This review was designed to be impartial, objective and not complaint-driven. For that reason, no active criminal or civil proceedings involving former residents of Woodlands formed part of this administrative review

and were specifically kept at arm's length, including the identities of people who had gone to the police. During the review, one former resident engaged in civil proceeding issued a subpoena to the person responsible for this review. The Supreme Court of BC vacated the subpoena on the basis that the review was protected by solicitor-client privilege and because the review had not been completed. Should government follow the recommendation of this report to undertake a second phase, all of those involved in criminal or civil processes, including criminal injuries compensation ["CIC"], should be invited to participate.

The findings and recommendations contained in this report ought not to be taken as a blanket condemnation of all of the staff and volunteers who ever worked at Woodlands. The interests of those who devoted their lives to providing professional care to the residents must be considered in the process that follows. Many hundreds of women and men worked over the institution's nearly 120-year history. The public and particularly the media ought to proceed with caution in reaching conclusions that they assume apply to all staff. Indeed, the primary focus of the review was not to locate and identify wrong-doers. It was to ascertain whether there was an institutional environment created that enabled perpetrators to victimize an extremely vulnerable population.

The rights revolution in Canada has given birth to claims for compensation and restoration by many minority and other marginalized groups. Most prominently this phenomenon has been linguistically, culturally or politically based. In all cases the claims have been founded on a demand for equality and to have rights respected. In recent years the claims for justice have come in waves of revelation of grave harms done to children and youth retained in institutions. These have emanated from residents abused and neglected in facilities for troubled youth, young offenders, orphans, deaf children, Catholic children, aboriginals, and people with a mental illness.

The claims that are based on a possible breach of inherent human rights such as the right to be safe from harm present the hardest of all cases for any government. Historically across the country governments, churches and service providers have shied away from any approach that could be considered progressive, with a few notable exceptions. Indeed, the field of historic abuse claims is flooded with denial, apathy, over-legalization, and bureaucratic responses. In BC this phenomenon has most recently been witnessed in the struggles of communities of deaf students, Doukhobour children and aboriginals.

For the purpose of this report, it is assumed that some human rights are inherent based solely on humanness. These rights are available to everyone and may or may not be reflected in the domestic constitution or legislation in place at the material time. Inherent human rights are not given to people in the same way as other rights, which are granted by law. The most relevant example for our purposes is the inherent right of all children and vulnerable adults to be safe from harm and abuse. When the government "wraps its arms" around children and adults in need and provides direct care in an institutional setting, there is clearly a fiduciary duty on the State to ensure that the right to be safe from harm is respected.

The residents at Woodlands were children and adults labelled "mentally retarded." For the purpose of this review, the inherent right paramount to the vulnerable children and adults labelled mentally handicapped who had been institutionalized was to be safe from harm. Initiating this administrative review of the records of Woodlands is an acknowledgement by the Ministry of the importance of its responsibility with respect to this right.

Any people who as children or adults have suffered harm at the hands of caregivers while institutionalized should be afforded the right to access a process of restitution. They should be able to enjoy the benefit of a process of reparation for any infringement of their inherent rights regardless of being labelled or diagnosed as having a mental handicap. In the case of former residents, many will have been considered legally incompetent, disenfranchised, and lawfully confined. Whether or not the law, at the material time, did or did not remove or grant rights vis a vis citizenship or legal competence is irrelevant today in considering any entitlement of this group to lay claim to justice for any harms done.

What is noteworthy about this review is that it was undertaken in an attempt to get at the truth, in preference to focusing on a strictly legal approach, historically

the more usual bureaucratic response to allegations of wrongdoing. This genuine values-based response is even more admirable given that the children and adults are primarily a group of people whom many have historically considered to make poor complainants or witnesses because of their intellectual abilities. As T. Marshall, QC, responsible in the Ontario department of the Attorney General for a number of historic abuse cases arising out of institutional settings, puts it:

> *'Reconciliation' is a word apt to describe the objective of integrating this particular group into the life of the community. Only in part does the word refer to the removal of the barriers created by trust abused. The larger context is to recognize that healing of the harm involved not only providing the means to change the circumstances of their existence, but to actively foster change. Merely providing money accomplishes nothing when self respect and a sense of dignity and worth are lacking. Indeed, there is a risk that throwing money at the problem is seen as the powerful dispensing a form of largesse to individuals clearly denigrated and remaining dependent in some ways. What was clear was that these people were powerless and, to achieve what we sought to do, it would be necessary to construct an ability on the part of the victims to approach the institutional interests on something like an equal footing.*
>
> *There were multiple parties involved. Each had a variety of separate and distinct interests. Motives for involvement varied and* ***any strictly legal analysis of liability issues would, I believe, have inevitably led to some kind of gridlock.***
>
> *[emphasis added]*
> *[T.C. Marshall, QC, "From Harm to Help", Vancouver Conference on ADR, March 11-12, 1994]*

This progressive approach allows those in a position to do so, to commit, at the earliest possible time, to a process of restitution based on an innovative model of justice. This is important because the actual process of how restoration is achieved is as important as a "just" outcome. In other words, justice must be seen to be done, as well as be done. The prompt response in this case by government allows for the opportunity to engage in such a new way of proceeding.

For example, a strictly legal approach may have encouraged the government who cared for the children or adults in Woodlands to defend against allegations of abuse by relying on the fact that they are people with a mental handicap. It would be inconsistent with the principles of dignity, respect and justice to rely on the same label that resulted in their institutionalization to ignore, denigrate or denounce any claim for compensation for injustices that occurred while they were confined or to deny them the opportunity to have their story told.

It is to the credit of the Ministry responsible that it has taken a proactive approach to investigating whether there was any evidence in the records of Woodlands of possible systemic, historic abuse of former residents. Determining this has not been an easy task. As in all cases of historic institutional abuse, documentation of relevant events may be scarce and incomplete. In some cases, given that Woodlands opened in 1878, many records had been disposed of under the relevant legislation. At the outset, the principal focus of the investigation was for the time period from 1976 to 1986. The period was chosen as the last decade of operations prior to active de-institutionalization beginning. While it is possible that some relevant records for this period have been destroyed or not yet located, there was sufficient documentation upon which Phase 1 could be completed. Given the records that were available, the period for the review was extended to include the period from 1975 to 1992. This report documents the findings and recommendations coming out of the administrative review.

This review began in the spring of 2000 and was completed at the end of June 2001. During the course of the work, the following records were examined:

1. Death and Critical Incident files.
2. Deceased resident records arising out of the Death files.
3. Coroner's records for residents who died at Woodlands or who were resident at the time of death, where available.
4. Senior Management administrative records for the Medical Director, the Manager, and the Deputy Superintendent.

5. Grievance, suspension and dismissal records of senior management.
6. Individual resident files of the residents named or referred to in the grievance, suspension and dismissal records.
7. The total number of records reviewed can be broken down into over 505 individual records contained in 361 accessions. A full tracking record for the files reviewed has been produced by Records Management specifically for the review and is protected by solicitor-client privilege as part of the report.
8. The records reviewed involved incidents ranging from 1975 to 1992 inclusive.
9. Records retained at the Legislative Library relating to Woodlands.

A concerted effort was made to locate the individual personnel records for those employees who were named as being involved in an incident, investigation, grievance, suspension or dismissal. Given the many changes within government departments during the lifespan of Woodlands, employee records changed locations on several occasions. The search led to a dead-end and it appears that the records may have been destroyed. It is unclear as to whether or not the individual personnel records would have provided any additional information on the relevant events disclosed in the senior management administrative records. There is no evidence that these records were destroyed for any reason other than in the ordinary course of document destruction and no negative conclusions ought to be drawn from the fact that to date they could not be located.

# DISCUSSION

Woodlands operated from 1878 to 1996. During the decade beginning in 1986, residents were de-institutionalized, with the majority finding community placements. The population of children and adults at Woodlands ranged over the life of the institution from as many as 1,200 children and adults to a few hundred during the final phases of closure. Children were placed in Woodlands by the Superintendent of Child Welfare when taken into care as wards of the State or by parents who admitted their children on a voluntary basis in order to receive medical and personal care, education, and training. Adults were admitted voluntarily by their principal caregivers or by the State under mental health legislation. They were placed in Woodlands because they had mental and physical disabilities. In order to be considered for admission, a diagnosis of mental retardation was considered essential.

The Law Commission of Canada in a recent publication on institutional child abuse refers to a "total institution," of which Woodlands is an example. Simply that means that every aspect of the resident's life was defined, controlled and provided for by those responsible for operating the institution. Unlike some institutions for children, Jericho Hill School for the Deaf and residential schools for aboriginal children being examples, the residents at Woodlands as a group did not have a regular or annual institutional reprieve at any time during any given year. Some residents had the opportunity to return to their family home for a visit but of the files reviewed the great majority appear to have had little if any contact with family or friends outside the facility. The lack of contact is frequently documented on residents' files.

Children and adults living at Woodlands had virtually no control over any aspect of their lives. The opportunities to make choices or to have any input into what their life looked like on a daily basis were extremely limited. The powerlessness and vulnerability of these children because of their placement in a total institution was further compounded by virtue of their being disabled. Like the deaf children at Jericho, the fact that residents had a disability may have interfered with their ability to communicate, thereby further contributing to their vulnerability. On top of these factors, these children and adults were considered medically and legally incompetent as "retardates" and, therefore, treated as if they were unable to speak for themselves and were lacking intellectual insight. This triple jeopardy situation – children, disabled, and mentally handicapped – placed them in an environment where their susceptibility to undetected, unmonitored and underreported abuse and neglect was potentially heightened.

By the late 1970s there was a clear policy that abuse of residents would not be tolerated:

> *Inherent in the philosophy [of Woodlands] is the understanding that all established goals developed to meet the objective, will ensure respect for the residents' individual rights. It then follows that abuse of any kind inflicted on residents is not condoned. Management expects that staff will practice a humanitarian approach in the care of residents.*
>
> *[Orientation of New Nursing Staff to the Ward – form signed by new employees]*

> *3.0*
> *Abuse of residents is forbidden by Woodlands, by Ministry policy and law. All incidents of abuse and/or suspected abuse must be reported. Staff found guilty of abuse are subject to discipline and/or the legal consequences of their acts.*
>
> *[Woodlands Procedure for Dealing with Resident Abuse dated November 8, 1978 revised March 1987]*

However, notwithstanding this strongly worded abuse policy, very little documentation could be located that demonstrates an informed approach to putting in place or to appreciating the importance of having internal safeguards to prevent abuse of residents. In any publicly funded facility serving vulnerable people, management bears the onus of ensuring a safe environment and needs to exercise due diligence to ensure clear policies and practices are in place outlining appropriate responses to residents with unique needs, challenging behaviours and alternate means of communication. When an institution knows that its constituency may not always be in a position to complain or be listened to, it is reasonable to expect that management will establish other means of quality assurance to strive towards an inherently safe environment.

> *Safeguards on paper for those in the care of institutions (secular and religious) are scant protection and, for those who live lives of detached isolation from participation in "mainstream" activities through choice or otherwise, barriers to relief may appear insurmountable. For significant numbers of people, subordination to and dominance by others and simply ignorance deprives them of effective routes to relief from oppression.*
>
> *[supra, T. Marshall]*

The institution management and senior officials within the responsible Ministry appeared in many cases to take reports of abuse and neglect at Woodlands very seriously. However, in every case reviewed, the focus throughout was to treat the matter solely as a personnel issue. This approach was certainly understandable but largely failed to take into account the needs of the individual residents and the responsibility to report to parents and relatives who remained involved in their lives. Indeed, and by way of example, no records could be located where a resident who had been hurt was assisted by counselling or in seeking compensation from CIC or other sources.

It would appear that in cases involving children in care, the Superintendent of Child Welfare might have been notified and marginally involved in follow-up. For parents and relatives in cases of voluntary admissions of children and adults equivalent notification did not appear to take place. This situation mirrors the dilemma for most parents of Jericho students, who did not receive reports and who, while they had the advantage of spending every summer with their children, could not for the most part communicate in American Sign Language. In the case of Woodlands, this failure to contact parents seems to be in direct contravention of the abuse priorities of the Woodlands Parents Group as outlined in their position paper issued in 1978, which provided in part:

> *Abuse of mentally handicapped persons cannot be tolerated, no matter where they live. Monitoring of all services must be such that it does not allow abuse to occur. Every person in our Province, including parents, must, by law, report all suspected or actual abuse of children...*
>
> *Priorities:*
>
> - *implementation of abuse reporting...*
> - ***full parent involvement when an abuse or injury occurs.***
>
> *[emphasis added]*
>
> *[Woodlands Parents Group: Position Paper, July 1978]*

In cases where there were credible witnesses or family involvement, management on occasion referred the matter to the local police for charges to be investigated. Even though, in at least one case, the victim was considered unable to testify, charges were still laid and criminal proceedings instituted. Nevertheless, it appears that the criminal justice system was not utilized frequently. This seems to be because of the nature of the disability of the alleged victims.

As of 1985, the *Criminal Code of Canada* provided for situations where "the offender, in committing the offence, abused a position of trust or authority in relation to the victim." Residents of Woodlands were wholly dependent on the staff. This dependency was all-inclusive and ever present including – medical care, toileting, bathing, dressing, grooming, social and recreational activities, bedtime and morning routines, personal hygiene including menstruation, and sexuality including masturbation. Staff represented or stood in the role of the resident's parent, nurse, doctor, and teacher. All the caregivers clearly were

in a position of trust and authority in relation to all of the residents whose whole lives were defined and controlled by the staff and their institutional routines.

Unfortunately, in the few criminal cases found there was an acquittal. For the purpose of this review, it is important to emphasize that an acquittal in a criminal proceeding does not mean there was no abusive conduct. It means that a Judge or Jury had a reasonable doubt, the standard of proof designed to protect the interests of the accused. It is natural for people to see a not guilty verdict as a pronouncement that the assault or abuse did not occur. This frequently results in police, Crown Counsel, institutional staff, families and residents being disappointed, disillusioned and reluctant to pursue the criminal route in future cases. However, as T. Marshall put it:

> *I don't want to be understood as saying that individual rights are unimportant. What I do want to be understood as saying is that a preoccupation with the rights of individuals accused of crime, for example, leads inevitably, it seems, to a disregard for the individual rights of the victims or, indeed, for the recognition that victims have rights. Standards of proof designed to "protect the innocent" from wrongful conviction, for example, have the consequence of providing substantial protection to the guilty and if, as a matter of public administration, decisions as to whether a particular individual should be permitted, on an "acquittal", to continue to minister to children, say, must be dependent on the outcome of criminal-like proceedings, substantial risks are simply perpetuated in the system. Prosecutions are not always successful and an acquittal is not tantamount to a finding of "innocence."*
>
> *[supra, T. Marshall]*

Unions have historically had a strong role in promoting human rights. Understandably the principal focus is for unions to support and defend members of the bargaining unit who are being disciplined by the employer. The tradition under collective agreements contracted to provide social and health services, as was the case at Woodlands, often failed to safeguard the rights and interests of the beneficiaries under the contract – that is the residents who were disabled. The unions cannot be faulted for this approach however, as the employer likewise responded to allegations of abuse as strictly a personnel matter. This focus meant that the institution gave little attention to what an internal oversight mechanism might look like beyond disciplining employees for contravention of the abuse policy. New employees were required to sign a short orientation form that indicated that they had been made aware of the terms of the abuse policy. When allegations were made against an employee, the employer frequently inquired as to whether the employee was aware of the abuse policy and whether the behaviour complained of in the employee's opinion fell within the institutional policy definition of abuse. There was some evidence that in-service sessions were held specifically on abuse issues but usually these were held after an incident had occurred.

Many historical abuse reviews have found a pattern where an employer simply removed a perpetrator from one situation and transported him/her to another venue where the person was able to inflict further harm albeit on another group of children. It is clear that those individuals seeking a place of employment where their aberrant behaviour could go unnoticed would gravitate to institutions housing the most vulnerable children. These included children who were discredited because they had been in conflict with the law and those who were without family support. Notwithstanding that many of the Woodlands' residents were placed as children in the institution by parents who attempted to remain connected, the reality of institutional living and the nature of their physical and mental disability put these residents at high risk. Woodlands would be considered an ideal workplace by a perpetrator seeking the opportunity to physically and sexually abuse children and adults who were silent, unable to complain, not knowing how or to whom to report or who would, in many instances, not be believed.

In many institutions reviewed by the Law Commission of Canada severe punishment and threats were used to dissuade children from reporting incidents of abuse. The perpetrators defended the use of harsh punishment as the appropriate way to improve aberrant behaviours of the children and youth in their care. Most residential settings were established to house children who were ostensibly in need of reform or training or assimilation. The rules governing appropriate use of

punishment did little to curtail abuse and often imposed the outside limits on what would be considered excessive. Indeed the *Criminal Code of Canada* then, and still, provides for a defence to an assault of a child by a caregiver or parent if the force used is reasonable. This defence has been found to be unavailable to a caregiver who assaulted an adult with a mental handicap.

During the period of time most at issue, the level of understanding of, sensitivity to and professional compliance with the issue of identifying and reporting child abuse were in their beginning stages. There were ongoing efforts to improve people's knowledge of the duty to report, to implement an integrated and consistent approach in various settings [for example schools, hospitals, group homes, and containment centres] and to ensure common understanding and compliance by all professionals [doctors, police, nurses, teachers, management]. While apathy, confusion, ignorance and stubbornness continued to plague the community, it is highly probable that these were even more prominent within an institutional setting such as Woodlands. It was not until June of 1976 that a Task Force on Protection of Children was constituted at Woodlands and Standard Institutional Procedures were developed as a result of that process. Also these procedures were designed to meet the requirements of the *Protection of Children Act* and outlined the method of reporting to the Superintendent of Child Welfare in cases involving children.

Many staff showed great affection and loving concern for the children and adults in their care. The use of behaviour modification techniques to adjust behaviour in an institution for the mentally handicapped was, however, considered an acceptable practice. Nevertheless, this conduct amounted to discipline that could be characterized as punitive. The residents, for the most part, were considered less intelligent, unable to appreciate instructions or normal teaching methods and, in many ways, less than human. It was assumed, therefore, that they were less likely to feel the same emotions or pain or experience the same thoughts as others not labelled. Disabled residents were often misunderstood, degraded and devalued to an even greater and more pronounced extent than many other institutionalized children. This attitude appears to have given some staff a free hand to treat residents harshly, rationalizing that the individuals involved probably did not understand or feel hurt and, in any event, required a strict disciplinary approach in order to learn. Such behaviour modification programs and assumptions are documented in the individual resident records.

The difficult behaviour of residents appears to have been used against them. Focusing on the aberrant behaviours of the resident and designing a behaviour modification plan that dealt with this legitimized some use of force and punishment. Strict responses were defended by employees as being normal and reasonable reactions to a resident who was acting out. Little consideration seems to have been given to the fact that the behaviours of residents were a legitimate response on their part to their continued confinement, constant companionship with only other people who were mentally and physically handicapped, absence of any concerted effort to socialize or integrate residents into a normal milieu and their boring, bland, sterile environment.

This aspect of the review was difficult. In an institution where much of the staff emphasis is on custodial care, often the needs of the children and their families are left wanting. Where 'training' was offered to the residents, it was often premised on a model of behaviour modification and the line between discipline and physical abuse became blurred. What constituted appropriate behaviour modification and discipline and what constituted physical abuse will need to be explored in much greater detail in the second phase of this review, benefiting from the opportunity to interview individual residents, staff and family members. In addition, when is the neglect of a resident of sufficient magnitude to constitute abuse? An audit was completed in September 1976 by a worker from the Child Abuse Team, Frances Grunberg, in cooperation with Ms. Susan Poulos, then Director of Resources at the Vancouver Resources Board in anticipation of the return of over 82 children from Woodlands to the Vancouver region. The audit highlights that there had been no complaints about abuse under the new legislation; the children were at high risk because of inadequate staffing; occurrence of abuse and injury were very plausible; and that while the wards and

children were clean, there was a danger of neglect due to inadequate programming. The records indicate that P. Hughes of Woodlands may not have seen the audit report until 1981.

Woodlands as an institution was officially phased out beginning over a decade ago with the last resident finding a community placement in 1996. There are, however, a number of previous residents who are at Willows Clinic on the old site for whom Woodlands has been their only home or for whom community placement continues to present a challenge. Many residents, now adults living in the community, previously lived at Woodlands for almost their entire lives. Many were admitted at a very young age. The period of time necessary for them to adjust to their new lives institution-free will be considerable. Concurrently some of these former residents will slowly become aware of what a non-institutional life looks and feels like. Many may begin to realize that life in Woodlands was not normal. Because most have some level of intellectual impairment, it is reasonable to assume that it may take them longer to realize the nature of the abuse they suffered. In other words, their mental handicap will not prevent them from figuring out what aspect of institutional life was dysfunctional and potentially wrong, it will just take them that much longer to become fully aware of it and to communicate it to others.

The challenge for government will be to not discredit any existing or future complaints by former residents because the person has a label of mental handicap. Equally important will be for government to establish a process of investigation and reconciliation for these former residents that is meaningful to them, does not exacerbate the harm done and accommodates their needs associated with their disability. Particular attention must be given to how they will be given the opportunity to tell their story, an important step in a reparation process. Many will communicate through alternate means and will need the assistance of a support person.

> *Listening is the oldest and perhaps the most powerful tool of healing. It is often through the quality of our listening and not the wisdom of our words that we are able to effect the most profound changes in the people around us. When we listen, we offer with our attention an opportunity for wholeness. Our listening creates sanctuary for the homeless parts within the other person. That which has been denied, unloved, devalued by themselves and by others. That which is hidden.*
>
> *[Dr. Rachel Naomi Remen, at p. 219]*

Many if not all of the former residents of Woodlands will have blossomed while living in the community. They may present, therefore, as being far more capable and competent than had been assumed or documented while they were in Woodlands. This may tempt government into wondering why the residents did not complain more openly and vigorously about the ongoing abusive behaviour. This temptation should be avoided at all costs given the known impact of a total institution, lack of family, community and police contacts and the extent to which residents were discredited and powerless.

# FINDINGS

## Finding 1 – Woodlands Presented the Opportunity for Abuse to Occur

1. One of the factors that is most commonly understood as being a pre-disposing factor to abuse occurring is that of opportunity. There is sufficient evidence to support a finding that Woodlands presented the opportunity for physical and sexual abuse to take place. There are many characteristics about Woodlands that can be identified as being relevant to this finding:

- Code of silence among many of the employees including those who were not engaged in abusive misconduct.
- A skewed view of what constituted appropriate discipline or conduct in responding to the needs of residents resulting in a disproportionately high level of tolerance for mean, abrasive, harsh and abusive behaviour.
- An institution that by virtue of its size and the nature of the service provided created a coercive, controlling and sterile environment.
- A population of residents labelled as mentally and physically disabled characterized as lacking intelligence and communication skills.
- Poor physical layout of wards and dayrooms resulting in poor sight lines, inadequate opportunities for observation of residents and frequent contacts between clients and staff behind closed doors in bathrooms and bedrooms that prevented visual scrutiny by supervisors or other third parties.
- Over-crowding on many wards over the history of the facility.
- Disproportionate and inadequate staff-resident ratios at all material times.
- Poorly paid, under-supervised and untrained staff.
- Frequent "intimate" contact between staff and residents during caregiving where respect for personal privacy was not always given due consideration or consistently respected because the ability of the residents to appreciate these sensibilities was discredited by staff.
- Fellow residents many of whom were not able to act as a witness, advocate or a person who could simply "go tell."
- Misuse of alcohol on the wards by a few staff members.
- An uninviting environment for family and friends where there was infrequent contact between residents and their loved ones on the ward or grounds. Except for planned social events on site, there was a lack of contact for residents with parents, family and friends particularly spontaneously and on the wards.

## Finding 2 – Abuse Occurred at Woodlands

2. The review of the documentation of administrative and resident files reveals a level of abusive conduct sufficient to make a finding that abuse in fact occurred at Woodlands. This finding relates only to staff-resident abuse and does not include resident-resident conduct that is better considered under the category of staff neglect of residents. This behaviour was not included in the terms of reference of Phase 1 of this review. Details of the abuse are as follows:

- The evidence that abuse occurred is documented primarily in grievance/dismissal/suspension files of

the senior management staff responsible for dealing with personnel issues involving abuse.

- Less frequently the specifics of these same incidents of abuse are documented on the resident's file. The actual details of the incident of abuse itself are often absent from the resident's file though evidence can be found on careful scrutiny of the resident's records that corroborates that the incident or incidents occurred, that injuries were sustained and how they were managed.
- It was difficult to find any written evidence of the actual reports made about the abuse to parents, family or the Superintendent of Child Welfare.
- Names of the residents and staff involved with incidents will remain private. Details of the physical abuse found in the records include hitting, kicking, smacking, slapping, striking, restraining, isolating, grabbing by the hair or limbs, dragging, pushing onto table, kicking and shoving, very cold showers and very hot baths resulting in burns to the skin, verbal abuse including swearing, bullying and belittling, inappropriate conduct such as extended isolation, wearing shackles and a belt-leash with documented evidence of the injuries including bruising, scratches, broken limbs, black eyes, and swollen face.
- Similarly the identities of those involved in the sexual abuse will not be revealed. The sexual abuse included assault, intercourse and in the result, injuries and in a few cases, a pregnancy. The documentation of these cases indicates a real problem for management in investigating because of the challenges of involving the residents.

## Finding 3 – Abuse Policy in Place

3. Management considered the possibility of abuse occurring at Woodlands. By the late 1970s there was a policy at Woodlands that abuse of residents, both children and adults, would not be tolerated.

*Inherent in the philosophy [of Woodlands] is the understanding that all established goals developed to meet the objective, will ensure respect for the residents' individual rights. It then follows that abuse of any kind inflicted on residents is not condoned. Management expects that staff will practice a humanitarian approach in the care of residents.*

*[Orientation of New Nursing Staff to the Ward – form signed by new employees]*

*3.0*
*Abuse of residents is forbidden by Woodlands, by Ministry policy and law. All incidents of abuse and/or suspected abuse must be reported. Staff found guilty of abuse are subject to discipline and/or the legal consequences of their acts.*

*[Woodlands Procedure for Dealing with Resident Abuse dated November 8, 1978 revised March 1987]*

While this policy addresses the issue of abuse, the wording failed to communicate a clear message that no form of abuse would be tolerated. It was clearly premised on a finding of "guilt" of a staff member. This was management's approach even though people were aware of the limitations of residents that presented an insurmountable barrier to accessing any process that determined guilt. A comparison with the wording of the abuse statement by the Woodlands Parents Group referred to in Finding 6 below demonstrates the point.

The procedure with respect to the Superintendent of Child Welfare activated the new legislative reporting requirements. The procedure made it clear that a report was mandatory regardless of a claim of privilege or confidentiality, that the person reporting could be provided immunity from prosecution, that witnesses could be subpoenaed to court and that there was a protection from liability for reporting in good faith. The procedure provided in part:

*Please note that reporting of such information is mandatory and that provision is made for protection of the complainant, i.e. "…no person is liable, by reason of the fact that they have provided information in good faith, to suffer any loss or damage as a result of their reporting."*

## Finding 4 – Responding to Allegations of Abuse, a Personnel Issue

4. In every case reviewed, the focus throughout was to treat the matter solely as a personnel issue. This approach was certainly understandable from the institutional employer's perspective but largely failed to take into account the needs of the residents and the responsibility to report to parents and relatives who remained involved in their lives. Indeed, and by way of example, in cases where a resident had been hurt and the complainant was not a relative of the resident, no records could be located indicating notice or a report to relatives or that arrangements had been made for the resident to receive counselling or that a claim of CIC had been filed.

## Finding 5 – Lack of Internal Safeguards to Prevent Abuse

5. There were insufficient safeguards or mechanisms in place to prevent or manage abusive conduct by employees in relation to residents. Although senior management of the institution had a policy of low tolerance regarding abuse of residents by staff, since at least 1976, this proved not to be sufficient for the following reasons:

- The enforcement mechanism to manage allegations of abusive behaviour was solely in the context of employee discipline, suspension and dismissal and therefore was focused on a combative approach between management and staff rather than any attention being given to protecting residents through prevention of, or recovery from, harm.
- Although there were in-service training sessions given from time to time, what constituted abuse for the purpose of reporting under the policy seems to have been widely misunderstood, ignored or underreported by some staff. The in-service that was held appears to have come as a result of new legislation or an incident.
- Given the code of silence among workers, the absence of outsiders from the community including family, friends and contractors, and the communication challenges faced by many of the residents, there was a distinct lack of sources from which complaints could emanate to trigger the policy or an investigation.
- There was no fixed point of responsibility for accepting, managing and investigating complaints. Though one person at a particular level of management was often designated to conduct in-house investigations of complaints, there does not appear to be a written policy regarding this complaint process or investigation mechanism.

## Finding 6 – Abuse Was an Issue for Parents

6. During the same time period, the Woodlands Parent Group issued a Position Paper regarding what they considered were the priorities with respect to abuse. This Paper was intended to highlight the immediate needs of the residents for Ministry authorities and for the Minister of Human Resources, then responsible. The full text read:

*ABUSE*

*Abuse of mentally handicapped persons cannot be tolerated, no matter where they live. Monitoring of all services must be such that it does not allow abuse to occur. Every person in our Province, including parents, must, by law, report all suspected or actual abuse of children. All persons, including parents, must also have a moral responsibility to report suspected or actual abuse of handicapped adults. Abuse by omission is a serious factor in the care of the handicapped.*

*PRIORITIES:*

- *implementation of abuse reporting*
- *maximum supervision to prevent abuse and injury*
- *change in policy re: staff dismissal (mandatory when abuse proven)*
- *removal of solitary confinement (siderooms)*
- *establishment of an abuse team from the community*
- *full access to residents' records*

- *full parent involvement when an abuse or injury occurs*
- *define abuses – physical, nutritional, mental, emotional, (behaviour modification, drugs, restraints, sexual, omission, commission, etc.)*
- *thorough assessment of staff on probationary period to monitor tendencies toward abuse*
- *appropriate staff supports for stressful areas*
- *weekend and relief staff to be fully qualified and appropriately briefed.*

This document was located during a literature search as part of this review. This document was not found with the senior management's records at Woodlands. No reference to it was made in the documents reviewed. Any actions taken by management in response to the priorities articulated by the parents group will have to be determined during Phase 2 of the review.

## Finding 7 – No Notice to Parents

7. In the cases reviewed, there was virtually no evidence that parents or relatives were notified when an incident involving a resident occurred if the parents or relatives did not file the complaint. While the Superintendent of Child Welfare appears to have usually been given notice when an incident involving a child or youth occurred, parents appear not to have been notified. If the original complaint of concern emanated from a relative, they were given information back, though not in a manner that appeared to be compassionate or informative. This failure to report incidents at all or willingly to loved ones outside the facility left a potentially natural oversight mechanism largely inoperable.

## Finding 8 – Little Evidence of Police Involvement

8. In a few isolated cases of abuse there was a referral by management to local police for charges to be considered. These cases seem to be those where there were credible non-disabled witnesses or family involvement. This did not seem to be dependent on the ability of the victim to be a participant in any criminal proceedings. Of all of the cases reviewed very few seem to have been referred to the police for investigation. The lack of contact or involvement with the police may have had the effect of eliminating one of the most effective deterrents to potential perpetrators.

## Finding 9 – Absence of an Integrated Approach to Abuse

9. Although there was a policy with respect to abuse at Woodlands, there was less evidence to support an integrated approach to the problem. At the time of implementing a new procedure for reporting to the Superintendent of Child Welfare in the late 1970s and as a result of one incident for which there was an investigation, there was an attempt by the then Superintendent to put a multi-disciplinary team in place to deal with abuse investigations at Woodlands. Also the person responsible for Staff Training appears to have made recommendations to the Manager at the time regarding an ongoing program on child abuse. The report from his Committee strongly supports the finding that abuse is problematic in relation to overlapping issues including behaviour management of residents, discipline of staff, unclear definition of abuse, and staffing problems, including numbers ["never enough"], training and orientation.

Notwithstanding that during the past two decades considerable attention has been paid to the issues surrounding sexual abuse of children, at the material time less attention seems to have been devoted to other vulnerable populations. This is particularly true concerning the lack of development of protocols regarding investigation of abuse or neglect in institutions. There is a preponderance of information in the Woodlands' records concerning conduct of investigations by RCMP, in schools and other locations throughout the community and protocols to ensure an integrated

approach with respect to children. It appears that less attention was given to the necessity for developing equivalent inter-agency protocols for managing incidents of abuse in large institutions where so many disabled children resided. The introspective approach of the institution not to involve outside agencies such as police, public health, victim support, and other ministries mirrored the institution as being self-sufficient and cut off from the outside community. There was in fact by 1983 a protocol regarding sexual abuse of children for Region 13, New Westminster, involving the Ministry of Human Resources and the local police but it does not appear to have included Woodlands.

## Finding 10 – Systemic Abuse

10. After a review of the records available, it has been determined that the abuse at Woodlands was systemic in nature. The details with respect to this finding are as follows:

- While some records are missing or have not yet been located, what information was available was sufficient to conclude that the abuse that is documented presented a significant problem for management.
- There is evidence that there was a code of silence. Although the policy in place was strongly worded, there were many references throughout the records to co-workers being hesitant to come forward to testify to the abuse. The apprehension seemed to be largely a question of fear of other staff's reaction to the employee who reported. The co-workers' reluctance does not seem to have been appeased by the protections provided in the child protection legislation.
- The revelation of abuse and the opportunity for management to take definitive action seem to have been largely dependent on fellow employees coming forward. Even in those cases where there was clear evidence of wrongdoing, some co-workers would attempt to deny the allegations or attest to not being a witness to the conduct complained of, in support of their colleague.
- The factors identified in the two preceding paragraphs combined to create a toxic environment where residents were seriously at risk. The protectionist attitude of many staff, and management's reactive approach to the issue of abuse rather than a proactive position of prevention, leads to the conclusion that a highly vulnerable population lived in an environment where perpetrators' abusive behaviour could potentially go largely undetected and underreported.
- A profile of who did report abuse emerged. Those who reported included family members, auxiliary staff, visiting nursing students, employees from departments other than the one to which the perpetrator was assigned and staff with courage knowing they would be identified as "snitches."
- In cases where the perpetrator was characterized as someone not well liked by other staff, people were less hesitant to file a complaint. The laziness and overall unacceptable personality were already annoying other co-workers who added their abusive behaviour to the litany of complaints about that worker. Those staff involved in incidents who were well liked were more often supported and defended by colleagues.
- There did not appear to be any mechanisms to guard against or to prevent abusive behaviour other than the policy and complaints filed by witnesses. In an environment where many of the residents were not in a position to complain or would not be believed, their vulnerability was exacerbated. Immediate supervisors or management investigated the majority of cases in-house. Very few cases were reviewed externally by police or outside investigators.
- Minimal contact by family and community within the institution. Save and except for special events planned by staff that included families, the general milieu seems to have been an unwelcoming place for families. This situation rendered a natural oversight mechanism inoperable.
- The following facts regarding patterns are instructive with respect to the finding that the abuse was systemic:

- In the majority of cases reviewed the impugned conduct of the employee involved more than a single, isolated incident and, in fact, there were usually many incidents of conduct for each employee against whom allegations of abuse were made.
- In most cases reviewed, the employee named was involved in incidents with more than one resident.
- Given the number of records available for review, a considerable number of employees were involved in allegations of maltreatment.
- The substandard treatment of residents by staff was repeated over time with no evidence of remorse on the part of the employees involved. While details of the incidents were documented, there was little indication that the person saw that what they did was wrong and that they were prepared to take responsibility for their actions. Rather they denied, minimized or excused their abusive conduct.
- It is unclear from the documents whether the individuals implicated intended to harm in a malicious sense or were simply ignorant of the severity of their conduct because Woodlands had failed to make it patently clear that such behaviour was totally unacceptable. This may become clearer when those involved, including former residents and management, have had an opportunity to be interviewed.
- There is little evidence that great care and attention were given to residents who had been victimized. Physical wounds were attended to by medical personnel, but no documentation could be found to indicate that the potential psychological harm was dealt with in an appropriate manner. It is reasonable to conclude that residents' level of fear of harm was exacerbated by the failure of the administration to address incidents of abusive conduct in an open and forthright manner.
- The employees implicated in abuse ranged from probationary staff to employees of long standing and included staff from different classifications including, for example, maintenance workers and Health Care workers.

## Finding 11 – Sterilization an Issue to be Considered

11. Sterilization of residents while at Woodlands will be an issue. Although the definition of sexual and physical abuse adopted for this investigation does not specifically include sterilization, given the recent Alberta experience, it is important to address the question at this stage. During a period of time while the institution was operational, eugenics legislation was in place in BC, authorizing sterilization in particular circumstances. Caution as to how to proceed in this matter must take into account the recent litigation initiated by the Public Guardian and Trustee of BC ["PGTBC"] on behalf of former residents of Riverview Hospital. There is some documentation recording the use of admissions to Woodlands as a means by which families and family doctors relied on the facility for a person to be considered for sterilization.

## Finding 12 – Review of Deaths and Critical Incidents

12. This investigation included a detailed review of management's Critical Incidents files and companion files for deceased residents. There were many examples of unexpected deaths occurring in questionable circumstances. The conclusions from this aspect of the review are as follows:

- Where there is misconduct surrounding an unexpected death, that misconduct may fall within the definition of neglect but falls short of the definition of abuse used in this review.

- The neglect often arose because of serious overcrowding, very poor staff-resident ratio [for example 6 staff to 72 residents on one ward], poorly equipped wards [for example inoperable, poorly situated or out-of-date suction equipment] and lack of staff training for the medical challenges facing many of the residents.
- Rarely was an employee singled out as the person responsible for the death of a resident. The death would have been reviewed either internally or in a few rare cases by the Coroner. Sometimes there were recommendations made to try to avoid a repeat of the incident for other residents. There did not appear to be any incidents where an employee was disciplined after such a review.
- Deaths were poorly tracked by any outside agency. Notice in some cases was given to the Coroner and medical examiner. In many cases autopsies were not done or were refused by families. Frequently brains of the deceased were transported to the University of BC for research but for study that appears to be unrelated to the death. Only one example of a Coroner's investigation could be found for a death arising out of a critical incident or a death that was unexpected. It appears that involvement by the Coroner was repeatedly signed off as unnecessary by medical staff at Woodlands.

## Finding 13 – Potential for Abuse Remains a Problem

13. The need to address the issue of abuse remains alive today. Although disabled people in BC may no longer live in large institutions like Woodlands, three realities need to be acknowledged:

- A large part of the vulnerability of people with a disability is that they live a life dominated by professional service providers who may be in a position to take advantage of their clients. This situation continues today although it may take place in community residences of all kinds but often cluster housing such as group homes.
- Notwithstanding BC's new guardianship legislation that is based on a presumption of competence for everyone, that presumption can easily be set aside for people who are visibly mentally handicapped ["some evidence of incompetence"].
- There is always the threat of a return to an institutional response to the care needs of people with disabilities hovering over the social service system. Understanding what life was like in Woodlands will presumably act as a deterrent to any retrograde change in policy to return to an institutional model. Some community living options, however, remain mini-institutional in fact and therefore how to prevent abuse occurring again remains critical.

# RECOMMENDATIONS

## Recommendation 1 – Second Phase Required

1. It is recommended that a second phase of the Woodlands review be undertaken within the immediate future. Given the finding that the available records of Woodlands are incomplete or unavailable, and the finding that the documentation reviewed reveals evidence of systemic abuse, it is important to continue the review. This next phase will give all of those affected the opportunity to come forward, be heard and to complete an investigation into systemic abuse at Woodlands.

   As part of the second phase, it is recommended that the review include all of the residents at Tranquille in Kamloops, the facility that was responsible for taking transfers when Woodlands was at capacity, and other Woodlands satellite sites such as Alder Lodge. Consideration should also be given to including the former residents of Glendale Hospital in Victoria where some residents were transferred during the deinstitutionalization of Woodlands and Tranquille.

## Recommendation 2 – Reparation Process

2. It is recommended that should the investigation phase confirm the finding of systemic abuse, government commit to a third and final stage that will focus on reparation of harm. Although individuals or classes of former residents may choose to initiate civil or criminal proceedings, it is reasonable to assume that many people bearing the label of mental handicap still face formidable barriers within the justice system. Former residents ought not to be forced to go to court. For these former residents to be forced to engage a judicial system that has been historically under-inclusive and inflexible with respect to accommodating for difference associated with having a mental handicap would be untenable.

   For this reason alone, it is suggested that government propose another approach to reparation. It would be improper for government to force people, some of whom will still be considered legally incompetent, to seek redress for the harm suffered in a historically unfriendly legal system. The focus ought to be on allowing people the opportunity to be heard, determining the harm done and providing compensation in the form of monies for counselling and healing. Entitlement to compensation ought to focus on the abuse perpetrated and not be based on the idea that people were wrongly confined in Woodlands.

   The bulk of the evidence that was eventually found to be highly probative was located in "garbage bags" destined for destruction shortly before this review began. To the credit of government personnel, prompt action retained these records and made them available. It was difficult to determine the extent to which other records have been lost because of previous destruction dates. There does appear to be a gap for some years of records of a similar nature from senior management.

   Furthermore, although there is a considerable amount of documentary evidence disclosing institutional abuse, the testamentary evidence from former residents, families and staff will likely be a major factor in clarifying the details of incidents and the harm suffered. The process of how this happens, therefore, becomes key. It must be a process that is open, inclusive and respectful.

   The experience in Ontario in at least two cases involving institutional harm is worthy of note.

The restitution process followed there provides considerable guidance and a resource for how the second phase should proceed.

## Recommendation 3 – The Need for Support for Former Residents

3. In pursuing the second phase, it is recommended that former residents receive support throughout the process. In other words, the process of the investigation itself must consider the impact it will have on the individuals. In some cases, it will mean opening up old wounds. For others, this may be the first time they realize what happened to them and that it was wrong. For those who were sexually abused, most will not have had the benefit of sex education or personal intimate contact and may therefore not have any means to distinguish between abuse and appropriate professional touching.

   The need to provide support also arises out of what may be happening for former residents at this time. Government should be on the alert for the 'behavioural fallout' from former residents now living in the community. Although BC has moved to being large-institution-free for people labelled mentally handicapped, some former residents are experiencing a lack of tolerance for their behaviours in the community. Some of these individuals who demonstrate aggressive or sexually inappropriate conduct find themselves in conflict with the law and are re-institutionalized, this time in forensic or correctional facilities. The possibility that this lack of understanding on the part of former residents for what is acceptable behaviour is a direct result of having suffered abusive behaviour at the hands of former caregivers should be given considerable thought.

## Recommendation 4 – The Need to Involve Family

4. It is recommended that the significant role of parents and other family members be addressed in the next phase of this review. Many parents felt an intense sense of despair, guilt and loss when they institutionalized their family member, although they did so voluntarily. Either they were encouraged to do so by the medical profession or they felt there was no other option because there were simply no resources or supports within the community. As children labelled mentally handicapped were apparently universally barred from regular schools, it is understandable that parents would resort to an institution ostensibly focused on training. The automatic response to medical complications or behavioural challenges was to place at Woodlands. In many cases, families seem to have considered Woodlands the only option.

   There were some examples of family members alleging abuse after having observed signs of potential harm to their family member during a home or facility visit. These were the exception. Few examples could be located of a family member being notified in writing by Woodlands authorities in a timely way that an investigation was being conducted for alleged abuse or that an employee had been suspended or dismissed for confirmed abusive behaviour. This failure to communicate effectively with families will exacerbate the residual guilt and anger felt by those families involved with Woodlands who may now realize that their family member may have been interfered with physically and sexually. Government should take this companion harm into consideration in any process coming out of this report.

   Parents may have unique needs during the investigation as secondary victims. There was, for many years, a group of very active parents at Woodlands who ultimately played a key role in closing the facility. The advantage of channelling input of family members through a reconstituted family group will be to facilitate the natural support engendered from membership in the group.

   Inclusion of families and friends in the process of reparation will also assist in strengthening supports for former residents. If the purpose of the reparation process is to enable residents to heal, the second phase should aim to strengthen natural bonds between families and former residents as a positive outcome of the process.

## Recommendation 5 – The Importance of Community

5. The community of disabled persons at large will be impacted by the ongoing investigation. How this community is engaged and the extent to which it needs to be part of the investigation process and be included as part of the reparation phase, should be considered at the outset of the second phase. There are always high expectations in the disabled community that they be consulted in any process that impacts on their constituents.

## Recommendation 6 – Legal Proceedings

6. There are apparently a number of legal actions already in process arising out of events that took place at Woodlands. These may include criminal investigations, criminal proceedings, CIC claims and civil actions. This review proceeded parallel to these other pursuits and has not been driven by these actions. Nothing should be done during the second phase of the investigation that would taint or jeopardize these existing processes. Having said that, particularly in the case of civil proceedings, government could consider the possibility of approaching the counsel, agents or advocates in those cases to invite former residents to engage in any reparation process arising out of this report.

A significant period of time has passed since the residents left the institution and, for many, since they suffered the documented physical and sexual abuse. The *Limitations Act* will not bar a claim involving sexual abuse but could in the case of physical abuse if the complainant is considered to have been "sleeping" on her or his right to sue for damages. Some of the residents will, in all likelihood, have to proceed with a claim either through their legal guardians or, with his consent, the PGTBC, and because of their disability postponing the limitation deadline, will not be considered statute barred. This is particularly true for those residents who remain unaware that what was done to them may be potentially actionable. For those who can proceed on their own, it is suggested that given their personal situation of being confined in Woodlands and suffering abuse from persons in a position of authority, it would be unwise for the government to make a statutory limitation argument even if the case is solely physical abuse. In fact, the court in the Alberta sterilization case took into account the Province's waiver of the limitation argument in considering the claim for punitive damages.

Some former residents apparently have initiated CIC claims. The review has not revealed any documentation regarding these claims since they may have been initiated after the closure of the facility. In those cases where harm was recorded there does not seem to have been any claim for criminal injuries initiated. That compensation scheme requires:

- A complaint filed with the police, though no charges need to have been laid as a result.
- A determination that on a balance of probabilities a crime was committed.

There may have been an onus on the institution to contact the police in all cases of abuse because its failure to do so may have disentitled the residents from a CIC claim. There is also question as to whether the institution also may have had the responsibility to advise the PGTBC of a potential claim for CIC on behalf of residents. The potential for claims to be made in this fashion should be considered in designing the process for restitution given that the CIC model is already in place and the experience in Ontario that relied on its existence.

## Recommendation 7 – The Importance of an Apology

7. An essential ingredient to any meaningful reparation process is that there be an opportunity to issue and receive apologies both individual, personal apologies and an official, collective, public apology. An apology by government to the community of former Woodlands residents and their families as a collective is required at the outset of the second phase. This will

be a public apology to the collective of former residents but not to particular individuals. Crafting an apology that is both meaningful for people with an intellectual impairment and thoughtful with respect to government's liability will deserve particular attention. Because of the importance of an apology, details of this recommendation are provided.

The legal system, both criminal and civil, creates an environment antithetical to apology. This is in fact one of the most compelling advantages of adopting the recommended reparation process rather than forcing parties to litigate. There is an abundance of caution among counsel, understandably, to the liability implications surrounding the particular wording of apologies. This, however, does not have to be the case. By advance agreement, apologies can be worded so as not to place offending parties in legal jeopardy. If the goal is the reparation of harm done and the beginning of a healing process, a meaningful apology is essential.

*Apologies are at the heart of the reconciliation process. In fact, healing from the personal devastation of abuse cannot occur without apologies.*

*[B. Hoffman, "The Search for Healing, Reconciliation, and the Promise of Prevention."]*

The immeasurable benefit of the voluntary issuance and acceptance of an apology in cases of abuse cannot be stressed enough. Given that a reparation model is the recommended and preferred course of action in this case and given that an apology is a key to the success of that process, there are several key points that ought to be considered at this stage:

a. **It is recommended that at the time of announcement of any process of second phase, government should negotiate with representatives of the former residents of Woodlands and the disability community, in advance, the terms of agreement upon which the public, collective apology would be based. Those would look like the following:**

   - The primary and secondary victims have a hand in crafting the terms of the public apology.
   - The parties acknowledge the importance of apologizing and agree to ensure that the personal and public apologies that are issued are meaningful.
   - The parties agree that the apologies made will not be presented or used as admissions of liability in other legal proceedings with respect to particular individuals.
   - The parties agree on the type, the timing, and the deliverer of the apology.
   - The parties agree that victims can opt in or out of receiving a personal apology and have a share in forming its contents.

b. **It is recommended that the apology be worded in such a way as to be meaningful. All of the fundamental elements of an apology must be present in order for it to be appropriate in the circumstances, acceptable to the victims if they choose to accept it and conducive to initiating or completing their healing. Alongside the necessary ingredients of a meaningful apology is a brief commentary stressing the relevance of that element to the Woodlands situation:**

   i. Acknowledgement of the wrong done or naming the offence.

      For the former residents of Woodlands this acknowledgement will be particularly important. That means that government should be cognizant of the need to give an unconditional acknowledgement of wrongdoing and avoid any form of explanation. For example, it may be tempting to address the harms done based on at least three factors.

      One is that at the material time there was a general malaise and an uninformed policy response to child abuse. Definitions of what constituted abuse and protocols to address it were in their formative stages. Second is that institutional care for people labelled disabled, particularly those considered mentally handicapped, was the service delivery model in vogue. A third factor could be the lack of

knowledge at the time about how to implement internal safeguards to prevent abuse occurring in an institutional setting. Although it may be relevant to consider these three factors in relation to appreciating why events transpired as they did, government ought to restrain itself from integrating such information into the text of the apology. The rationale for the acknowledgement of wrongdoing not incorporating any explanation is that doing so will make the apology sound defensive and may actually exacerbate the harm done to the victims:

*Any diversion from accepting responsibility is not an apology. Because of this stringent requirement, an apology may indeed afford victims and bystanders something that trials, truth-telling [commissions], and monetary reparations or property restitution cannot. Full acceptance of responsibility by the wrongdoer is the hallmark of an apology.*

*[M. Minow, Between Vengeance and Forgiveness – Facing History after Genocide and Mass Violence, at p. 115]*

ii. Accepting responsibility for the wrong that was done.

The apology must admit a wrongdoing to the injured parties and state unequivocally that there is no excuse for the harm.

There is a precedent in this province for the kind of apology that will meet the requisite standard. As a result of an Ombudsman recommendation for an apology in the report of abuse of children and youth at Jericho Hill School for the Deaf, the Attorney General issued an apology, which is a notable example:

*The events [the sexual abuse] …should never have occurred. There is no excuse or justification for what happened. The victims bear no responsibility for events over which they had no control.*

*[Ministerial Statement on Report on Abuse of Students at Jericho Hill School, Legislative Assembly, Debates Hansard (28 June 1995)]*

iii. The expression of sincere regret and profound remorse.

Former residents of Woodlands have, over the last two decades, begun to enjoy previously ignored human and social rights. The right to the equal benefit and protection of the law free of discrimination is protected by s. 15 of the *Canadian Charter of Rights and Freedoms*. These protections place them on equal footing with all other Canadians, although the full meaning of that equality remains largely undefined by the courts. Many of the rights that had previously been ignored left people with a mental handicap legally disenfranchised and considered second-class citizens.

Caution must be exercised in the course of this reconciliation process not to trigger any backward slide from the advances made in recent years. By expressing regret by way of an apology similar in kind to the Jericho apology, government will be recognizing the importance of adopting an equitable, fair and balanced approach to a group of people who have historically suffered considerable discrimination and marginalization.

iv. The assurance or promise that the wrong done will not recur.

This aspect of the apology will have special meaning for people who were former residents. There is clearly an improved understanding of and appreciation for the abilities of people labelled disabled. British Columbia is committed to being an institution-free province for people who have a mental handicap as evidenced by the closure of Woodlands in 1996.

However, people who formerly would have been placed at Woodlands continue to live in places that may heighten their chances of being abused and live lives that can, in some instances, be highly dependent on professional care and service providers. The government who operated Woodlands continues to serve

this population through its responsibility for, and control of, the service delivery system that supports community living. Therefore, the need to have an assurance contained in the apology that the wrong will not recur and that such violations will not be countenanced now or in the future, takes on a particular importance.

*Just as acknowledging the harm done can serve to set the record straight or reclaim the moral ground lost, when making an official apology, formally undertaking to ensure that the wrong done will not recur can provide much-needed reassurance that the reclaimed moral ground will not be lost.*

*[S. Alter, "Institutional Child Abuse", at p. 15]*

c. **The timing of the apologies, both public and personal, is of critical importance. It is recommended that a group apology be made at the outset of Phase 2. In order to make a group apology as a beginning to the process of reconciliation, all of the individuals do not need to be named or personally identified. Once it has been determined *prima facie* that abuse has occurred, a formal, public apology can be issued without the particulars of individual cases. This serves three purposes:**

The first is that it sets in motion a process of reconciliation that is civil, non-adversarial and progressive. The second is that the public apology is general enough and therefore is unlikely to be "probative evidence of liability in individual compensation claims" which may be of particular importance to government. Finally, it avoids the harm that results for individuals from delayed apologies. There have been dramatic examples of anger, resentment, depression and suicide resulting from what is considered an inordinate delay in the delivery of an apology in other cases where historic abuse in institutions has been reviewed.

The outline of the wrongdoing and the personalization of the apologies to individuals can be later in the process, the details of which will form a part of the long-term process. However, again, caution must be exercised to ensure the timing of these individual apologies is not inordinately or inappropriately delayed.

d. **It is recommended that government consider the content and format of the apology, that both are significant. Precedents are instructive.**

The apology to the interned Japanese was in both English and Japanese and was beautifully framed. It was publicly issued in the House of Commons although not by the member of Cabinet of choice. The apology to the Jericho victims, as previously discussed, was delivered in the Legislative Assembly by the Attorney General and was concurrently interpreted on site and on television in American Sign Language.

For former residents of Woodlands the form of the apology will require considerable thought. The use of plain language, Blissymbolics, American Sign Language, and advocates as interpreters are all factors that may be relevant. Who will issue the apology on behalf of government and when and where it is to be issued are matters that ought to be given significant thought.

## Recommendation 8 – What the Investigation Phase Will Involve

8. In addressing the issue of historic, systemic abuse at Woodlands, government has chosen a process that is progressive and developmental. It was intended that the review process would proceed from one step to the next based only on concrete findings and desired outcomes. The three phases contemplated at this time are:

Phase 1: Administrative Review [completed]

Phase 2: Investigation Stage [recommended]

Phase 3: Reparation Process [conditional on the outcome of Phase 2]

The sole purpose of the initial administrative review was to ascertain if any harm was done to former residents while at Woodlands to an extent that the abuse could be considered systemic and not to focus on identifying the alleged perpetrators. If any person or persons are identified during the investigation stage whose conduct is such that a referral to the responsible officials is appropriate such a referral will be made.

The principal goal of this process has been, and continues to be, to facilitate healing of the victims of any abuse at Woodlands while at the same time avoiding regressing into an approach, like the one taken in the past, that focuses on disciplining or prosecuting wrongdoers. In achieving that goal, it is recommended that the following details be taken into account in the investigation process:

a. **Many former residents will require accommodation during the investigation, which should:**
   i. Be designed to meet the unique needs of the particular resident
   ii. Be focused on enabling each individual to communicate, for example through the use of:
      - an advocate, friend or support person
      - blissymbolics
      - computerized programs
      - PIC board
      - sign interpreter
      - elder
      - language translator
   iii. Take into account the time and place of the interview such that it respects the person and his or her present situation and promotes rather that detracts from a sense of personal well-being
   iv. Allow for access to counselling which will be offered to former residents throughout the process where the investigators determine that such a referral would be timely and appropriate
   v. Be provided at no cost.

b. **The process of engagement will need to be unique because of the nature and extent of the disability of many of the former residents, what their lives are like now and the communication challenges many face. Therefore to maximize the information made available to the investigating team, the following steps will be required:**
   i. a high profile and public announcement regarding the decision by government to follow the recommendation to proceed with the investigation phase. Such a public announcement will enable former residents and their families/friends/advocates to know that they have the opportunity to come forward and be interviewed
   ii. the investigation team will consist of seasoned investigators who will be supported in their work by a social worker, psychologist, aboriginal counsellor, physician, researcher and/or counsellors who are sensitized to the issues facing people who have mental and physical disabilities and who have been institutionalized
   iii. the investigative interviews will be held in private to allow people to tell their story without embarrassment or fear of retribution and will be recorded through the use of audio and, where appropriate, video
   iv. included with the public announcement will be an invitation to specific agencies who represent the interests of people with physical and mental disabilities. These agencies play a special role with respect to this group of individuals who have been historically disenfranchised and marginalized. These agencies will assume a dual role. The first is as a potential source of names of former residents and parents who may need to be contacted in order to know about the investigation. The second role will be to provide a broad perspective on the occurrence of abuse at Woodlands and information on how to

prevent its recurrence in community settings in the future

v. a request will be made to the Community Living Services for Adults Branch of the Ministry of Children and Family Development for a locator list, as much as is available, to ascertain the whereabouts of particular former residents of Woodlands identified during Phase 1 as possible victims. An invitation will be extended to these individuals that will include a clear outline of the process to be followed during the investigation and, in particular, the aids and assistance available.

c. **The investigation process will be principle-based. This will enable government to proceed with the third reparation of harm phase, should it decide that a final stage is appropriate. The central principles will be:**

*Every person involved at Woodlands is entitled to dignity, respect and the opportunity to be heard during the investigation, including all former residents, institution and ministry staff, families, union representatives, volunteers and contractors.*

*The primary goals of the process are to make an objective, accurate and fully informed determination of the facts and to facilitate the reparation of harm for those affected.*

*The design of the investigation process will take into account the duty to accommodate people who have a disability and will, whenever possible, rely on plain language.*

d. **Particular attention will be paid to prevention. One of the main reasons for initiating and continuing with this process is to shed light on what factors contribute to the vulnerability of people who have a disability. Although Woodlands is closed, the great majority of adults who have a disability continue to reside in situations involving considerable dependency and/or group living. The investigators will devote considerable time to interviewing on this aspect in order to identify causative factors and to design tangible means to prevent abuse from recurring.**

e. **A report of the investigation making up Phase 2 will be made publicly available. Like this report, all efforts will be made to respect the privacy of all of the individuals involved at Woodlands. The Phase 2 report will make a recommendation to government as to whether Phase 3 should proceed.**

## Recommendation 9 – Who Needs to be Interviewed

9. In conducting the second phase, it is recommended that the following categories of people be interviewed in addition to those outlined in Recommendation 8:

a. **Select individuals who worked for Woodlands or were associated with the institution at all or a portion of the material time who were identified during Phase 1 as having been involved with cases of alleged abuse at Woodlands in their role as senior administrators at the institution but who were not themselves implicated in the abuse.**

b. **Persons within government and the relevant ministries including Children and Family Development, Human Resources, Social Services and Health who may have some personal knowledge of relevant events between 1976 and 1996.**

c. **Representatives of the union primarily the BCGEU, the New Westminster police, and particular individuals who were not employees of Woodlands but who were responsible for other reviews of the facility.**

d. **Former residents from Woodlands who were identified during the first phase as being involved in or having information with respect to allegations of abuse. These former residents are entitled to their privacy and therefore their names are not included in this report and will not be made public now or at any time in the future.**

e. Individuals who came forward after the Vancouver SUN article in the spring 2001. The author of the SUN article and those individuals who called were advised that Phase 1 involved an administrative review only. The direct contacts were asked to submit a letter to the Deputy Minister and informed that their names would be recorded for the second phase if one was recommended and conducted.

f. Former employees who were identified as complainants or witnesses in cases of alleged abuse of residents.

g. Parents or relatives of Woodlands residents who were identified as being involved with particular incidents or the issue of abuse during Phase 1.

## Recommendation 10 – The Need to Address Sterilization

10. Sterilization may have taken place for both permanent and, on occasion, for temporary residents of Woodlands. It is unclear whether the sterilization took place at Woodlands, by way of transfer to Riverview Hospital [then Essondale] or arranged by family physicians in the community. In the case of the latter, it appears that people were often admitted to Woodlands for the specific purpose of being considered as candidates for sterilization. It is recommended that government consider two factors in relation to sterilization.

For many of the years that Woodlands was open, there was eugenics legislation in place authorizing sterilization of people with a mental handicap. Such legal authority, however, may not protect the Crown from being held responsible, given the recent experience in Alberta.

The PGTBC recently commenced an action for damages against the Province of BC on behalf of former female residents allegedly sterilized while institutionalized at Riverview Hospital. Whether any of these plaintiffs are also former residents of Woodlands has yet to be determined. A preliminary motion by the PGTBC was successful in styling the cause of action on the basis of the plaintiffs' initials only to protect their privacy. This makes cross-referencing of potential overlapping claimants difficult though counsel for the Province has indicated that he believes at least one of the plaintiffs may have also resided at Woodlands. The PGTBC has indicated that he was unsuccessful in uncovering evidence to support a like claim on behalf of former Woodlands residents. No information about this review, specifically regarding sterilization or more generally, has been shared with the PGTBC.

Parents were asked to consent to the surgery particularly where they were the legal guardian or committee of their family member. It is now well-established law that legal guardians do not have the authority to consent to sterilization unless it is for therapeutic purposes. The impact of that decision operating retroactively to apply to these events remains to be seen. The Alberta sterilization case indicates that notwithstanding legal authority, sterilization may be actionable.

## Recommendation 11 – Concrete Measures

11. One small facility for people who have mental handicaps is presently operating on the Woodlands site. The residents have been identified as individuals whose placement in the community has broken down, who require assessment or who have caregivers who require a period of respite. In addition, the property has been used as a movie site. The property continues to be managed by the Province who owns the land. In contemplation of the possibility of compensation being paid out to former residents and their families, it is recommended that government consider the revenues from the use or sale of the property itself as a source of funds.

This is for two reasons. First, former residents and their families view the site as their former home and have strong feelings about what will happen to the site in the future. Second, there may be a tremendous opportunity to make a definitive,

positive, symbolic statement through the establishment of a trust fund from the sale or rental proceeds. The use of funds in this way achieves two positive outcomes – commitment to closure of institutions like Woodlands for people with mental handicaps and a source of funds that can be held in trust for compensation for the former residents.

It is important at the outset of Phase 2 to commit to reparation through concrete measures. While the details of the appropriate concrete measures will take considerable discussion between government and the primary and secondary victims following the second phase of the review, suffice to say this at the outset. There are two excellent precedents within Canada that may be helpful to consider as the process continues.

In both the case of the interned Japanese and the aboriginals who endured residential schools, a trust fund was established as one of the concrete measures to accompany an apology. In the case of the aboriginals the trust fund was intended to support community specific healing initiatives. In the case of the Japanese the fund was to promote educational, social, and cultural well-being of the community and to promote human rights. There may be an opportunity to establish a similar fund for former residents of Woodlands.

This could be accomplished if government looks favourably on the report's suggestion to consider the proceeds of the lease or sale of the Woodlands land as a definitive source of capital to establish such a trust. The amount and purpose of the trust would form part of the reconciliation process. At the present time, the Province, through the BC Buildings Corporation, is negotiating with the BC Assessment Authority and the City of New Westminster regarding the future development of the Woodlands site. These parties could be put on notice to avoid the land being dealt with in the short term in a manner inconsistent with acting upon this course of action in the long term. This recommendation is not that government commit at this time to the sale of or to the dedication of the proceeds from any future sale or lease of the Woodlands property. The recommendation is simply for government to consider this as a possibility should Phase 3 proceed and take whatever steps now that it considers appropriate to preserve this as an option for itself in the future.

## Recommendation 12 – The Woodlands Graveyard

12. Government needs to be cognizant of the fact that the graveyard at Woodlands was dismantled and the headstones were used to construct an outdoor section of stairs and patio. The ground where the headstones were located prior to being removed remains intact. It is presently identifiable as a graveyard by a simple plaque and is located behind the Willows Clinic. Some of the gravestones can be located. The actual plot has otherwise not been disturbed except that people have been known to walk across it. The facts surrounding the dismantling of this graveyard have gained some notoriety and are known to many longstanding employees of government, former residents and families and advocates. Why this was allowed to happen is not clear. Government should be alerted to the fact that for many people this dismantling of the graves is indicative of the lack of respectful treatment afforded the residents while alive.

    Some of the residents who may have been the victims of abuse have died. Given the long period of time during which Woodlands was operational, many residents died on site. There were cases documented of untimely and unexpected deaths of residents, which could be accurately characterized as resulting from neglect – understaffing, poor equipment, and inadequate personal care and attention. The terms of reference of this review did not extend to neglect unless of such a magnitude as to fit within the definition of physical abuse. However, the Ministry should be aware that as the second phase proceeds, additional information about the psychological and physical neglect or maltreatment could surface.

A negative connotation may be drawn about the value and dignity afforded the lives of Woodlands' residents given the disturbance of this resting place of the deceased. Government should be in a position to deal with this issue as part of the reparation process.

It is therefore recommended that the terms of reference of Phase 2 include specific direction to the investigators to ascertain the history and present status of the graveyard at Woodlands.

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